U.S. Department of Labor

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Issue Date: 27 February 2004

In the Matter of:

HOWARD W. EUBANKS,
Claimant,

CASE NO: 2003BLA5391

v.

FREEMAN UNITED COAL MINING COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Appearances:

Chris L. Gore, Esquire
For the Claimant

Christina B. Conlin, Esquire
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

Statement of the Case

This proceeding involves a subsequent claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. 901 *et seq*. ("the Act") and the regulations promulgated thereunder.[1]

[1] The Department of Labor's amendment of the regulations implementing the Federal Coal Mine Health and Safety Act of 1969 became effective on January 19, 2001, and was published at 65 Fed. Reg. 80,045-80, 107 (2000)(codified at 20 C.F.R. Parts 718, 722, 725, and 726 (2003)). Citations to the regulations, unless otherwise indicated, refer to the amended regulations. The

Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies. §718.2. Because the Claimant was last employed in coal mine work in the state of Illinois, the law of the United States Court of Appeals for the Seventh Circuit controls. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Procedural History

Howard Eubanks (the "Claimant") filed his initial claim for benefits under the Act on March 13, 1974 (D-1-1). The District Director ultimately granted benefits to Claimant on August 19, 1980 (D-1-29). Freeman United Coal Mining Co. (the "Employer") controverted the finding on September 15, 1980 (D-1-30). In an Initial Determination dated April 6, 1981, the Director determined that Claimant was eligible for benefits (D-1-35). The claim was referred to an administrative law judge on September 10, 1981 (D-1-36).[2] The claim was ultimately denied in a Decision and Order dated March 1, 1984, by Administrative Law Judge John C. Holmes, because Claimant had not proved any of elements necessary to establish entitlement (D-1). Claimant appealed on June 20, 1984, but withdrew the appeal on September 5, 1984 (D-1).

Claimant filed a subsequent claim for benefits on October 25, 1991 (D-2). The District Director denied the claim on April 8, 1992, because Claimant had not proved that his pneumoconiosis was caused by coal mining, or that he was totally disabled by the disease (D-2). Claimant filed a second subsequent claim for benefits on July 26, 1993 (D-3). The Director denied benefits on October 26, 1993, because Claimant had not proved that he was totally disabled by pneumoconiosis (D-3). Claimant filed a request for modification on March 10, 1994, which was denied by the Director on August 22, 1994 (D-3). Claimant filed a second request for modification on January 8, 1995 (D-3). The Director reaffirmed the denial in a Proposed Decision and Order Denying Request for Modification dated March 9, 1995 (D-3).

Claimant filed the immediate subsequent claim for benefits July 18, 2001 (D-6). In a Proposed Decision and Order dated September 19, 2002, the Director granted benefits to Claimant (D-23). Employer requested a hearing before an administrative law judge on October 18, 2002 (D-32). A hearing took place before this tribunal on October 29, 2003, in Murphysboro, Illinois.[3]

Issues

1. Whether, under §725.309(d), Claimant has shown that one of the applicable conditions of entitlement previously decided against him has changed since the previous denial of

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Director's exhibits are denoted "D-"; Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr."

[2] In the Initial Finding, the Director stated that if the Employer did not start payments to Claimant, then the claim would be referred to an administrative law judge. It is assumed that the Employer did not start payments because there is no record of the Employer requesting a hearing before an administrative law judge in the file.

[3] Director's exhibits one through twenty-eight and Employer's exhibits one through nine were admitted into evidence at the hearing (Tr. 5, 7, 15).

benefits on March 9, 1995, by establishing that he is totally disabled by a respiratory or pulmonary impairment, or that he is totally disabled by pneumoconiosis?

2. If so, whether Claimant has established the elements of entitlement to benefits under Part 718?

FINDINGS OF FACT

Background

Claimant was born on January 30, 1919, and completed the eight grade of education (D-6). Claimant alleged that he completed twenty-one years of coal mine employment, ending in April, 1981 (D-7). Claimant's Social Security record indicates sixteen years of coal mine employment, which is uncontested by the Employer (D-9, 28). Claimant has not submitted evidence or testimony that supports a twenty-one year coal mine employment history. Therefore, it is determined that Claimant has sixteen years of coal mine employment. Claimant last worked in the coal mining industry for Employer as a cut and loader operator (D-7). Claimant married Evelyn Eubanks on February 22, 1938 (D-11). They were currently married and living together at the time of the hearing (D-6, Tr. 19).

According to Dr. Repsher, Claimant stated that he smoked two to three cigarettes a day for five to six years and stopped smoking in 1971 or 1981 (E-4). Claimant testified at the hearing that he smoked four to five cigarettes a day for five to six years, and that he did not inhale (Tr. 30-31). According to Dr. Houser, Claimant smoked a half a pack of cigarettes a day intermittently from 1935 to 1998 (D-13). Several physicians who examined Claimant prior to the previous denial recorded a smoking history of one-third of a pack a day for twenty years to one-half of a pack a day for forty years to a sixty pack year smoking history, and that he was currently smoking in 1993 did not plan to stop smoking at that time (D-1-3, E-7). Based on Claimant's carboxyhemoglobin, Dr. Repsher opined that Claimant was currently smoking two to three packs a day at the time of the examination in 2003 (E-4). Claimant's relation of his smoking history to Dr. Repsher, Dr. Houser, and other physicians, and his testimony on his smoking history are inconsistent, not credible, and unreliable. It is evident that Claimant had an extensive cigarette smoking history, which this tribunal finds to be a thirty-four year pack history based on Dr. Renn's estimates and Dr. Houser's report.

Medical Evidence Developed Subsequent to the Closing of the Record on Which the Prior Denial was Based

X-Rays[4]

Exhibit No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation

[4] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read as completely negative for pneumoconiosis.

Exhibit No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
E-1	1/4/00	Scott	R/B	2	0/0
D-13	10/26/01	Whitehead	R/B	Not noted	1/0, t/s
D-14	10/26/01	Sargent	R/B	1	Read film for quality only
E-3	10/26/01	Wheeler	R/B	2	0/0
E-2	2/5/02	Scott	R/B	2	0/0

Pulmonary Function Studies[5]

Exh. No	Test Date	Age/ Ht	Doctor	Co-op./ Undst./ Conf.?	FEV1	FVC	MVV	Qualify
D-13	10/26/01	82/ 69.5”	Houser	Good/ Good/ Yes	1.71 1.74	2.88 3.57	- -	No[6] No
E-4	4/15/03	84/ 70”	Repsher	Good/ Good/ Yes	1.49 1.52	2.82 3.30	- -	No No

Arterial Blood Gas Studies

Exh. No.	Test Date	Physician	Conform?	pCO2	pO2	Qualifying
D-13	10/26/01	Houser	Yes	43.5	67.9	No
E-4	4/15/03	Repsher	Yes	43.6	61.7	No

[5] The second set of values indicates post-bronchodilator studies. Because the heights range between 69.5” and 70”, this tribunal averaged the numbers and used 69.75” as the height of Claimant.

[6] Dr. Katzman, who is board certified in internal medicine, opined that the vents were acceptable (D-15).

Medical Reports and Opinions

Dr. William Houser[7]

In connection with a medical report dated October 26, 2001, Dr. Houser, who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant. Dr. Houser recorded that Claimant had a twenty-two year coal mine employment history. Claimant's most recent duties included cutting and loading coal, and working as a miner operator, performing medium to heavy work. Dr. Houser recorded that Claimant smoked one-half pack of cigarettes a day "approximately 1/3 of the time" between 1935 and 1998. A pulmonary function study revealed moderately severe airway obstruction with no response to bronchodilator administration. Based on an arterial blood gas study, Dr. Houser opined that Claimant had mild hypoxemia. Dr. Houser diagnosed claimant with coal workers' pneumoconiosis (CWP), moderately severe chronic obstructive pulmonary disease (COPD), and arteriosclerotic heart disease with previous inferior and possible anterolateral myocardial infarction. Dr. Houser opined that the CWP was related to Claimant's coal mine employment of twenty-two years with exposure to coal and rock dust; the COPD was related to former cigarette smoking and coal mine employment; and the arteriosclerotic heart disease was related to cigarette smoking and the "male sex." Dr. Houser concluded that Claimant's overall degree of impairment was severe and that Claimant was physically unable to perform his previous employment as a coal miner. Dr. Houser opined that Claimant was disabled from a "respiratory standpoint as well as a cardiovascular standpoint" and that the COPD and arteriosclerotic heart disease were significant contributing factors to Claimant's impairment. Dr. Houser opined that CWP was a mild to moderate contributor to Claimant's disability and that it "probably" contributed to the hypoxemia. (D-13)

[7] Employer argues that because Dr. Houser's credentials are not a part of the record, there is no way to determine the credibility of Dr. Houser's finding. *See Consol. Coal Co. v. Director, OWCP*, 294 F.3d 885, 893 (7th Cir. 2002)(holding that a litigant must satisfy the ALJ that their experts are qualified by knowledge, training, or experience, and have in fact, applied recognized and accepted medical principals in a reliable way.) However, in the Notice of Hearing, this tribunal reserved the right in its discretion to take judicial notice of the qualifications of any such doctor using the world wide web. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990). Employer had more than sufficient time to address the issue in the months before the hearing. In addition, the Supreme Court has held that an agency may take judicial notice of facts outside of the record and "the mere fact that the determining body has looked beyond the record proper does not invalidate its action unless substantial prejudice is shown to result." *See U.S. v. Pierce Auto Freight Lines*, 327 U.S. 515, 530, 66 S.Ct. 687 (1946). Employer has not shown that substantial prejudice would result from this tribunal's recognition of Dr. Houser's credentials. Therefore, this tribunal has taken judicial notice of Dr. Houser's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org.

Dr. Lawrence Repsher

In connection with a medical report dated May 7, 2003, Dr. Repsher, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, examined Claimant and reviewed specified medical records. Dr. Repsher recorded that Claimant worked as a coal miner for twenty-three years, and stopped working in 1981. Claimant informed Dr. Repsher that he smoked up to two to three cigarettes per day for five to six years, and that he chewed tobacco in the past. Claimant alleged that he "never inhaled the cigarettes" and that he quit smoking in 1971 or 1981. Dr. Repsher noted that Claimant informed Dr. Houser that he had smoked up to one half pack of cigarettes per day for sixty-three years.

Upon examination of Claimant's lungs, Dr. Repsher recorded that there were no rales, rhonchi, or wheezes, even on forced expiration. Pulmonary function tests showed moderately severe COPD with no significant immediate bronchodilator response, with a diffusing capacity at the lower limits of normal. The arterial blood gas tests revealed moderate hypoxemia and mild CO2 retention. Claimant's carboxyhemoglobin was "markedly" elevated, which Dr. Repsher opined was consistent with a current two to three pack per day cigarette smoking habit.

Dr. Repsher opined that Dr. Whitehead found no evidence of CWP on x-ray, because he only found irregular opacities in the mid and lower lung zones of 1/0 profusion. He opined that CWP is manifested on x-ray by rounded opacities (p, q, and r) in the upper and mid lung zones. Dr. Repsher opined that Dr. Houser incorrectly opined that Claimant's COPD was caused by coal mine dust, concluding that the "overwhelming probability" is that Claimant does not have clinically significant COPD as the result of his exposure to coal mine dust and that his pulmonary function tests would have been no different had he never set foot in a coal mine.

Dr. Repsher diagnosed Claimant with, *inter alia*, moderately severe COPD without emphysema, secondary to a "probably" long and heavy cigarette smoking habit; coronary artery disease; and recurrent pneumonia. Dr. Repsher concluded that Claimant did not have CWP, or any other pulmonary or respiratory condition, either caused by or aggravated by exposure to coal mine dust. He based his conclusions on a lack of radiographic evidence of CWP[8]; a lack of pulmonary function test evidence of CWP, because CWP is "primarily a restrictive disease" and Claimant had a "pure" obstructive disease, which is characteristic of cigarette smoking induced COPD; and a lack of arterial blood gas evidence of CWP, because Claimant had an elevated PCO2, which is characteristic of severe cigarette smoking induced COPD. Dr. Repsher opined that Claimant was also suffering from several other serious medical conditions, including coronary artery disease, but none of the diseases were related to Claimant's work as a coal miner with inhalation of coal mine dust. (E-4)

[8] Dr. Repsher partially relied on an x-ray reading that was not admissible in concluding that Claimant does not have CWP. The x-ray reading, included in Employer's exhibit four, is not admissible because Employer designated two other x-ray readings on its evidence submission form, and under the regulations a third x-ray reading is inadmissible. However, Dr. Repsher relied on numerous x-ray readings, CT scans, and other medical evidence that was admissible, and his use of the inadmissible evidence is cumulative and therefore his opinion is still viewed as probative.

In a deposition taken on October 10, 2003, Dr. Repsher opined that the opacities described by Dr. Whitehead in his x-ray reading are typical of a person with respiratory bronchiolitis or "RBILD" which are caused solely by inhalation of cigarette smoke. Dr. Repsher opined that Claimant's pulmonary function tests showed a low FEV1/FVC ratio, which is characteristic of obstruction, and suggest COPD of a moderate to moderately severe extent. In observation of Claimant's smoking habit, Dr. Repsher opined that there was no explanation for Claimant's elevated carboxyhemoglobin test, other than cigarette smoke inhalation. Dr. Repsher opined that Claimant's smoking history was very heavy, "probably well exceeding 100, maybe even approaching 150 pack-years." However, Dr. Repsher opined that even if Claimant had only a thirty pack year smoking history, his x-ray, pulmonary function test, and arterial blood gas study findings would indicate that Claimant was more sensitive to cigarette smoke than the average smoker, and a change in smoking history would not affect Dr. Repsher's opinion on the cause of Claimant's abnormalities. (E-9)

Dr. Joseph J. Renn

In connection with a medical report dated July 16, 2003, Dr. Renn, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, reviewed specified medical evidence, including an x-ray performed by Dr. Repsher on April 15, 2003, that was not admissible[9]. Dr. Renn recorded that Claimant had a twenty-three year coal mine employment history as a roofbolter, miner operator, laborer, and buggy operator and retired in 1981. Dr. Renn noted that Claimant had an extensive smoking history and that Claimant often related different smoking histories to the various examining physicians. Based on a review of Claimant's smoking history, Dr. Renn opined that Claimant had smoked cigarettes for thirty-four pack years. Dr. Renn opined that Claimant had, *inter alia*, chronic bronchitis owing to tobacco smoking with an asthmatic component; bullous and probably centrilobular emphysema owing to tobacco smoking; and moderately severe, significantly bronchoreversible obstructive ventilatory defect owing to his respiratory diseases. Dr. Renn opined that none of Claimant's diseases were caused, or contributed to, by his exposure to coal mine dust. With respect to Claimant's respiratory system, Dr. Renn opined that Claimant was permanently and totally impaired to the extent that he would be unable to perform any of the coal mining jobs listed under his occupational history or any similar work effort. Dr. Renn concluded that Claimant's impairment is "wholly" a result of the tobacco smoke-induced diseases of chronic bronchitis with an asthmatic component, and bullous and probably centrilobular emphysema. Dr. Renn opined that Claimant did not have pneumoconiosis. (E-5)

In a letter dated September 5, 2003, Dr. Renn opined that "neither clinically, nor physiologically, nor radiographically" did Claimant demonstrate CWP. Dr. Renn opined that Claimant's twenty-three years of coal mine employment was a sufficient amount of time to cause CWP, were Claimant a susceptible individual. Dr. Renn opined that Claimant did not have industrial bronchitis caused by coal mining, because Claimant's chronic productive cough began late in his coal mine dust exposure history, 1976, and was still present on April 15, 2003, and

[9] Dr. Renn also partially relied on Dr. Repsher's x-ray reading that was not admissible in concluding that Claimant does not have CWP. However, Dr. Renn relied on numerous x-ray readings, CT scans, and other medical evidence that was admissible, and his use of the inadmissible evidence is cumulative and therefore his opinion is still viewed as probative.

because chronic bronchitis generally disappears completely within approximately six months of cessation of exposure. Dr. Renn opined that Claimant did have chronic bronchitis, caused by Claimant's smoking, based on his opinion that chronic bronchitis caused by smoking does not disappear, despite cessation of tobacco smoking, and Claimant was still smoking as of April 15, 2003. In addition, Dr. Renn opined that Claimant's ventilatory function studies revealed that there was a significant bronchoreversible component, thereby attesting to the presence of bronchospastic airways "(asthmatic component)" disease which is known to be associated with persistent inflammatory reaction of chronic bronchitis caused by tobacco smoking, and does not occur with industrial bronchitis. Claimant had an asthmatic component of chronic bronchitis "owing to tobacco smoking," which Dr. Renn opined was evident from Claimant's symptomatic history of wheezing during exercise, and which began in either 1993 or 1995. Dr. Renn opined that wheezing is not a symptom that occurs in CWP or industrial bronchitis.

Dr. Renn declared that, clinically, Claimant has had shortness of breath, exertional dyspnea, chronic productive cough, wheezing, orthopnea, and paroxysmal nocturnal dyspnea. Dr. Renn opined that individuals with CWP do not develop wheezing, orthopnea, or paroxysmal nocturnal dyspnea. Dr. Renn opined that Claimant's orthopnea and paroxysmal nocturnal dyspnea are symptoms of left ventricular cardiac failure. Dr. Renn opined that when Claimant was admitted to a hospital on December 8, 1996, he had erythrocythemia, which results from tobacco smoking and not CWP. Dr. Renn declared that the lung volume studies reveal a normal total lung capacity, and not a restrictive pattern associated with CWP. Dr. Renn opined that Claimant's diffusing capacity was mildly reduced, but the diffusing capacity corrected for the alveolar volume was normal, which is not characteristic of CWP, but is characteristic of tobacco smoke induced COPD, specifically, emphysema. Dr. Renn opined that the arterial blood gas studies revealed a normal gas exchange, and that there was no clinically significant CWP that was interfering with gas exchange.

Dr. Renn opined that radiographically, Claimant did not have the changes that are associated with CWP, and the "overwhelming vast majority" opinion of physicians is that the radiographic evidence did not exhibit changes consistent with pneumoconiosis. Dr. Renn observed that three CT scans performed did not reveal changes consistent with CWP. However, they did reveal changes of bullous and probably centrilobular emphysema, which are associated with tobacco smoking and not CWP. Dr. Renn opined that Claimant did not have focal emphysema, which is associated with CWP. Dr. Renn concluded that Claimant did not have CWP. (E-5)

Various Medical Reports

In a series of x-ray interpretations of x-rays dated from 1983 to 2001[10], several different doctors of various qualifications read x-rays of Claimant's chest. There were seventeen readings by various physicians of eighteen chest x-rays dated from 1983 to February 9, 1995, sixteen read by board-certified radiologists, and one by a physician with unknown qualifications. There were nine readings by various physicians of nine chest x-rays dated from 1996 to 2001, two by board-

[10] These x-rays were nonconforming because they did not indicate film quality. In addition, there was no indication that the films were read for pneumoconiosis, they were general and vague, and some were illegible due to poor copy quality.

certified radiologists and seven by physicians with unknown qualifications. The interpretations indicated that there was evidence of moderate chronic obstructive lung disease with interstitial fibrosis, emphysema, and pulmonary scarring. Several physicians observed chronic changes consistent with pulmonary disease in their x-ray interpretations. There was one reading of CT scan performed by Dr. Sanjabi on January 19, 1992. Dr. Sanjabi, whose qualifications were not found in the record or on the internet, diagnosed Claimant with, *inter alia*, chronic obstructive lung disease, left-sided apical pulmonary scarring, scattered pulmonary granulomata. Dr. Sanjabi opined that there was no obvious pneumonia or pleural abnormality. (E-6).

In two chest x-rays dated May 23, 2000 and May 16, 2001[11], Dr. Nair, a board certified radiologist, observed moderate to advanced COPD with scattered interstitial fibrosis and a "possible" small patchy infiltrate within the left lung base with blunting of the left costophrenic angle which "may be due to pleural thickening vs. small pleural effusion." In a CT scan dated June 28, 2002, Dr. Nair observed, *inter alia*, no pulmonary nodules, no pleural effusion or pneumothorax, mild scattered interstitial fibrosis. (E-8)

In a medical report dated November 7, 1993, Dr. Sanjabi opined that Claimant had a sixty pack year smoking history. Dr. Sanjabi diagnosed Claimant with COPD and bronchitis. In a medical report dated November 7, 1993, Dr. Sandoval, who is board-certified in internal medicine and the subspecialty of pulmonary disease, stated that Claimant currently smoked at the time of the examination and that Claimant was "noncommittal to quitting smoking." Dr. Sandoval diagnosed Claimant with, *inter alia*, COPD associated "probably" to bronchitis of probably viral etiology and nicotine addiction. (E-7)

In a CT scan dated April 16, 2003, Dr. Schultheis, who is board-certified in diagnostic radiology, opined that the lungs were hyperinflated and that there were no consolidations or pulmonary nodules. He opined that there was some mild irregular pleural thickening at the left base, but that there was no "ground glass" opacity or pleural calcification. Dr. Schultheis also observed mild peribronchial thickening. (E-4).[12]

Conclusions of Law and Discussion

Subsequent Claim

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For the purpose of the Act, pneumoconiosis, commonly known as black lung, means a chronic dust disease of the lung, and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A

[11] These x-rays were nonconforming because they did not indicate film quality. In addition, there was no indication that the films were read for pneumoconiosis, and they were general and vague.

[12] Employer submitted this CT scan with Employer's exhibit four and did not separately designate this CT scan on the evidence submission form as "other evidence." However, because there is no limitation on CT scans and because there are a substantial number of other radiographical readings this evidence is recognized as "other evidence" and this omission, while not condoned, is viewed as nonprejudicial.

disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201. In order to obtain federal black lung benefits, a claimant must prove by a preponderance of the evidence that: (1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary impairment; and (4) pneumoconiosis contributed to the total disability. 20 C.F.R. §725.202(d)(2)(2001); §718.204.

Material Change in Conditions or Change in Applicable Conditions of Entitlement

Since the instant claim was filed more than one year after the denial of Claimant's previous claim, it is considered a subsequent claim under the Act. §725.309(d). Under the amended regulations, a subsequent claim shall be denied on the grounds of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. §725.309(d). In essence, the amended regulations codified the holding of the Fourth Circuit in *Lisa Lee Mines* that, to establish a material change in conditions, a claimant must prove at least one of the elements previously adjudicated against him, based on newly submitted probative medical evidence of his condition not available at the time of the prior claim. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 20 B.L.R. 2-227 (4th Cir. 1996)(*en banc*). In the instant claim, the previous denial was based on the finding that Claimant had not established that he was totally disabled by a pulmonary or respiratory impairment, or that the disability was caused by pneumoconiosis. Therefore, in order to establish entitlement, Claimant must establish that one of these conditions has changed since the date of the denial of the prior claim.

Total Disability

This tribunal has reviewed the medical evidence to determine whether a material change of conditions or a change in applicable conditions of entitlement has occurred. To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

Under §718.204(b)(2)(i), both pre-and post-bronchodilator pulmonary function studies must be weighed when reviewing relevant evidence. *See Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). The fact-finder must determine the reliability of a study based upon its conformity to the applicable quality standards, and must consider the medical opinions of record regarding

reliability of a particular study. *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

The record indicates that the Claimant underwent two pulmonary function studies in connection with the pending claim. Both studies conform to the standards for pulmonary function studies required under §718.103. Neither study produced qualifying results. Therefore, the preponderance of the pulmonary function study evidence does not establish total disability pursuant to §718.204(b)(2)(i).

Two blood gas studies were performed on Claimant. Both studies conform to the standards for arterial blood gas studies required under §718.105. Neither study produced qualifying results. Therefore, the preponderance of the arterial blood gas study evidence does not establish that Claimant was disabled pursuant to §718.204(b)(2)(ii). Since there is no evidence of cor pulmonale with right-sided congestive heart failure, Claimant has not proved total disability pursuant to §718.204(b)(2)(iii).

Dr. Renn and Dr. Houser opined that Claimant was totally disabled by a pulmonary or respiratory disease. Dr. Repsher did not specifically state that Claimant was totally disabled, but he did conclude that Claimant had moderately severe COPD, and this is consistent with the findings of Dr. Renn and Dr. Houser. No medical opinions were submitted that would rebut a finding of total disability. Because the medical opinions establish that Claimant has a total disability, Claimant has proved by a preponderance of the evidence that he is totally disabled by a respiratory or pulmonary impairment as required under §718.204(b)(2)(iv) and has proved a material change in conditions or change in one of the applicable conditions of entitlement.

Review of All Evidence

Because the preponderance of the pulmonary function studies and reasoned medical opinions establish that the Claimant is totally disabled by a respiratory or pulmonary impairment, Claimant has established a material change in conditions or change in one of the applicable conditions of entitlement. When a claimant demonstrates a material change in conditions or change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue shall be binding on any party in the adjudication of the subsequent claim. §725.309(d)(4). Therefore, the subsequent claim is considered a new and viable claim to be reviewed *de novo* and Claimant must prove four elements to receive benefits: (1) the existence of pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause to his total respiratory disability.

Existence of Pneumoconiosis

The definition of pneumoconiosis includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis. See §718.201. Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§718.304, 718.305, and 718.306; or (4) the finding by a

physician of pneumoconiosis as defined in §718.201 which is based upon objective evidence and a reasoned medical opinion. Since there is no evidence that Claimant suffers from complicated pneumoconiosis, the presumption set forth in §718.304 is inapplicable. Since the claim was filed after January 1, 1982, and since this is not a survivor's claim, the presumptions set forth in §§718.305 and 718.306 are inapplicable as well. No biopsy has been performed on Claimant.

The existence of pneumoconiosis requires consideration of "all relevant evidence" under §718.202(a), as specified in the Act. Thus, if a record contains relevant x-ray interpretations, biopsy reports, and physicians' opinions, the Act would prohibit a determination based on x-ray alone, or without evaluation of physicians' opinions that the miner suffered from "legal," as opposed to traditionally clinical, pneumoconiosis. *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 B.L.R. 2-104 (3d Cir. 1997); *Island Creek Coal Co. v. Compton,* 211 F.3d 203, 22 B.L.R. 2-162 (4th Cir. 2000).

The record contains over thirty-two interpretations of over eighteen chest x-rays.[13] Ten of the probative readings were positive for pneumoconiosis, fourteen were negative, and two were unreadable. Eleven negative readings and five positive readings were made by dually qualified board-certified radiologists and B-readers. One negative and two positive readings were done by board-certified radiologists only. One positive reading was performed by a B-reader only. Five negative readings and four positive reading were performed by readers with unknown qualifications. One positive reading was performed by a board-eligible radiologist only. The majority of the readings performed by dually qualified physicians, who are better qualified to read x-rays than physicians who are only qualified as B-readers or board-certified radiologists, and non-qualified readers, opined that the x-rays were negative for pneumoconiosis. In addition, three of the most recent x-rays were read as negative for pneumoconiosis, while one, whose film quality was not noted by the reading physician[14], was read as positive.[15] Because the most recent and the majority of the x-rays were negative for pneumoconiosis, the radiographic evidence alone does not establish that the Claimant has pneumoconiosis under §718.202(a)(1).

In a well reasoned medical opinion that was supported by specified medical evidence, Dr. Repsher opined that Claimant did not have pneumoconiosis, based upon an examination of Claimant and a review of Claimant's extensive medical data. Dr. Renn also opined in a well reasoned medical opinion that Claimant did not have pneumoconiosis, based on a review of Claimant's extensive medical data. Their opinions are supported by the opinion of Dr. McDonald, dated January 19, 1982 (D-1).[16] The opinions of Drs. Renn and Repsher are clear

[13] An additional x-ray was read by Dr. Sargent for quality only. There were numerous chest x-ray interpretations that were not on x-ray forms. Several included a reading for pneumoconiosis and included the category of pneumoconiosis, or clearly stated that there was no pneumoconiosis, and these are included in the general summary of x-ray readings. However, there were many readings that were not read for pneumoconiosis, and were general, vague, and nonconforming, and they were given little weight.

[14] Dr. Sargent read the film separately and opined that the film quality was "1".

[15] Employer argued that Dr. Whitehead's opinion should be given less weight because he has not been a B-reader as long as Drs. Scott or Wheeler. The length of time a B-reader has been qualified is not relevant under the regulations.

[16] Dr. McDonald's qualifications could not be found in the file or on the internet.

and adequately explain their findings. Drs. Houser, Sanjabi, and Khan[17] all opined that Claimant had pneumoconiosis, Dr. Sanjabi in five reports dated from June 18, 1979, to August 23, 1993, and Dr. Khan in a report dated September 16, 1994 (D-1-16, 1-17, 2, 3). Dr. Khan and Dr. Houser relied primarily on x-ray readings in opining that Claimant had pneumoconiosis. The opinions of Drs. Khan and Houser are contrary to this tribunal's findings that the x-ray evidence does not support a finding of pneumoconiosis, so that they are not well reasoned, and their opinions are given little weight. In addition, the opinions of Drs. Khan, Sanjabi, and Houser do not reflect a review of Claimant's medical data, unlike the opinions of Drs. Renn and Repsher, which reflect a review of Claimant's extensive medical data and are better supported by the medical data. Dr. Khan, Dr. Sanjabi, and Dr. Houser provide no basis for their medical conclusions that Claimant had pneumoconiosis, absent the x-ray evidence. While Drs. Renn and Repsher partially relied on evidence that is inadmissible, they reviewed Claimant's medical history as a whole, and their opinions are given greater weight than those of Drs. Houser or Khan, who only reviewed limited data in concluding that Claimant had pneumoconiosis. While Dr. Sanjabi appears to have examined Claimant over several years, there is no evidence that he was Claimant's treating physician and his opinion is not given greater weight for that reason. In medical reports dated November 7, 1993, Dr. Sanjabi and Dr. Sandoval opined that Claimant had, *inter alia*, COPD and bronchitis, but did not opine on the etiology of the diseases and their opinions are given little weight. The physicians who read the three CT scans of record did not opine on the existence or absence of pneumoconiosis and their readings are given little weight.

Dr. Repsher and Dr. Renn are board-certified in internal medicine and the subspecialty of pulmonary disease, and are B-readers. Dr. Houser is board-certified in internal medicine and the subspecialty of pulmonary disease. Dr. Khan is board-certified in internal medicine. The qualifications of Dr. McDonald and Dr. Sanjabi are unknown. Because Drs. Houser, Repsher, and Renn are dually qualified in internal medicine and the subspecialty of pulmonary disease, their opinions are given more weight than those of Drs. Khan, McDonald, and Sanjabi. Therefore, because Dr. Renn's and Dr. Repsher's opinions are better reasoned and better supported by the medical data, and because they are better qualified than all physicians, with the exception of Dr. Houser, Claimant has not proved by a preponderance of the evidence that Claimant has pneumoconiosis under §718.202(a)(4).

Claimant argued that he is entitled to a presumption of pneumoconiosis under 20 C.F.R. §410.414(b)(1). However, the amended regulations, §718 and §725, instituted on January 19, 2001, apply to this claim because it was filed on July 18, 2001. Therefore, Claimant is not entitled to any presumption of pneumoconiosis under 20 C.F.R. §410.414(b)(1). Claimant's statements regarding Dr. Repsher's fees, his association with Employer, and his treatment of patients are ambiguous and unclear. Employer has a right to have Claimant examined by its chosen physician prior to the hearing. §725.414. Claimant has not proved that Dr. Repsher showed any bias in preparing his report.

[17] This tribunal has taken judicial notice of Dr. Khan's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org.

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established at least sixteen years of coal mine employment. Therefore, Claimant is entitled to the presumption that pneumoconiosis arose from his coal mine employment under the provisions of §718.203(b). However, because Claimant did not establish that the Miner had pneumoconiosis, the issue of causation is moot.

Total Disability

Claimant has established that he is totally disabled due to a pulmonary or respiratory impairment under the evidence submitted with the duplicate claim. Dr. Sanjabi opined that Claimant had a mild obstruction and Dr. Khan opined that Claimant was totally disabled due to a respiratory disease. Dr. McDonald did not opine on Claimant's disability. There is nothing in the past evidence that would prevent this tribunal from concluding that Claimant has established that he is totally disabled by a preponderance of the evidence under §718.204(b)(2)(iv) as discussed.

Total Disability Due to Pneumoconiosis

To establish entitlement, a claimant must prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. A miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.* In a well reasoned and well documented report, Dr. Renn opined that Claimant was totally disabled by a respiratory disease caused by Claimant's extensive smoking history, and that coal mine dust did not contribute in any way to Claimant's disability. Dr. Renn explained in a persuasive manner how smoking affected Claimant and why he was able to diagnose smoking as the cause of Claimant's respiratory disease. Dr. Renn's opinion was supported by Dr. Repsher's well reasoned and well documented report. Dr. Repsher's report was persuasive in diagnosing the cause of Claimant's respiratory obstruction. Drs. Houser and Khan opined that Claimant was totally disabled by pneumoconiosis, but due to this tribunal's finding that Claimant did not have pneumoconiosis, and because their opinions are contrary to medical evidence of record, their opinions are given less weight than those of Drs. Renn and Repsher. Dr. Sanjabi only opined that Claimant had a mild impairment, and did not opine that Claimant was totally disabled. There is no persuasive or substantial contrary evidence of record. Therefore, Claimant did not prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. In addition, because this tribunal did not find that Claimant had pneumoconiosis, the issue of disability by pneumoconiosis is moot.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claim before this tribunal.

ORDER

The claim of Howard Eubanks for benefits under the Act is denied.

A

EDWARD TERHUNE MILLER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.